Event # _____
DMH Use Only

Department of Mental Health
EMT – Community Event Report Form – ADA/CPS

Division *(select one)*: ☐ Alcohol and Drug Abuse (ADA) | ☐ Comprehensive Psychiatric Services (CPS)

1. Event Date & Time ____/____/____ ____:____☐AM ☐PM
Month Day Year

2. Discovery Date & Time ____/____/____ ____:____☐AM ☐PM
(Complete this section only if different than event date/time)

3. Event Location or where discovered (Name of agency or location)

4. Name of Provider Agency/Organization involved in event &

VENDOR NUMBER (*required*):

5. EVENT CATEGORY (CHECK ONE) ☐ **INCIDENT (Includes Death)** ☐ **MEDICATION ERROR**

6. PROGRAM CATEGORY PERTINENT TO EVENT

ADA Only: ☐ **Adult or** ☐ **Adolescent, then choose:** ☐ **PR+** ☐ **CSTAR** ☐ **Level 1R** ☐ **Level 1** ☐ **Level 2** ☐ **Level 3** ☐ **SATOP** ☐ **Recovery Support** ☐ **Non DMH-Funded**

CPS Only: ☐ **Adult or** ☐ **Youth, then choose:** ☐ **Community Services** ☐ **Community Psychiatric Rehab** ☐ **SCL** ☐ **Targeted Case Management**

7. REPORTABLE EVENT All events identified below shall be recorded on this form and faxed within one business day to the appropriate *Division of Alcohol and Drug Abuse District Administrator or Division of Comprehensive Psychiatric Services Supported Community Living Office.*

☐ Death (all deaths, including those of consumers within 30 days post-discharge from residential programs) **If checked, complete suspected manner (14)**

☐ Injury resulting in Hospitalization **If checked, complete 9, 10, 11**

☐ Elopement/Unauthorized Absence- when absence raises reasonable concern for the safety of consumer or others, or concern the consumer will not return. For ADA, this applies to adolescents and involuntary commitments only.
Return Date: Time ____:____ ☐AM ☐PM

☐ **MEDICATION ERROR** - -Occurring in residential programs or programs in which medication is administered or self administration is observed by agency

Severity ***(SELECT ONE)***
☐ **Moderate:** Treatment and/or interventions in addition to monitoring or observation
☐ **Serious:** Life threatening and/or permanent adverse consequences

Medication Error Category
☐ **Failure to Administer**
Reason_____
_____
☐ **No Physician Order**
☐ **Wrong Dose**
☐ **Wrong Form**
☐ **Wrong Medication**
☐ **Wrong Person**
☐ **Wrong Route**
☐ **Wrong Time**

☐ **Alleged or Suspected Abuse, Neglect, or Misuse of Funds/Property**
Select Type (all that apply): ☐ **Verbal Abuse** ☐ **Physical Abuse** ☐ **Sexual Abuse** ☐ **Neglect** ☐ **Misuse of Funds/Property**

If Physical Abuse, Verbal Abuse, Sexual Abuse, Misuse of Consumer Funds/Property, or Neglect is alleged by a consumer or suspected by staff, report this immediately by verbal or written report and follow all other procedures described in 9 CSR 10-5.200.

8. Persons Involved – Please PRINT (attach pages if necessary)	**Relationship**	**Role**	**DMH State ID #** (for consumers)	**Date of last Service** (for consumers)

Relationship Types: Consumer, Parent, Guardian, Staff, Visitor, Volunteer, Other – specify.
Role Types: Complainant, Perpetrator, Victim, Witness, Other- specify

9. INJURY TYPE ***(SELECT ONE)*** ☐Accident ☐Consumer Inflicted ☐Other Inflicted ☐Self Inflicted ☐Staff inflicted ☐Unknown

10. INJURY DESCRIPTION ***(CHECK ALL THATAPPLY)***
☐Abrasion ☐Heat related Illness
☐Bite ☐Laceration/Cut
☐Burn ☐Puncture
☐Complaint of Pain ☐Scratches
☐Contusion/Bruise ☐Strain/Sprain
☐Dislocation ☐Swelling
☐Fracture/Break ☐Other (specify)
☐Frostbite _____

11. INJURED BODY PARTS ***(CHECK ALL THAT APPLY)*** ***(CIRCLE R or L BELOW)***

☐Head		☐Shoulder	R/L	☐Lower Back		☐Knee	R/L
☐Face		☐Upper Arm	R/L	☐Abdomen		☐Calf	R/L
☐Eye	R/L	☐Elbow	R/L	☐Waist		☐Shin	R/L
☐Ear	R/L	☐Forearm	R/L	☐Hip	R/L	☐Ankle	R/L
☐Nose		☐Wrist	R/L	☐Genitals		☐Foot	R/L
☐Mouth		☐Hand	R/L	☐Buttock	R/L	☐Other	
☐Teeth		☐Chest		☐Thigh	R/L	_____	
☐Neck		☐Upper Back					

FINGERS		TOES	
☐Thumb	R/L	☐Big	R/L
☐Index	R/L	☐2nd	R/L
☐Middle	R/L	☐3rd	R/L
☐Ring	R/L	☐4th	R/L
☐Little	R/L	☐Little	R/L

☐**Event or** ☐**Discovery Date and Time:** _____ ____:_____ **AM/PM**

12. NOTIFIED:	Name of Person Contacted	Date	**Time**
☐**Family or Guardian**			____:____ ☐AM ☐PM
☐**Physician**			____:____ ☐AM ☐PM
☐**Law Enforcement**			____:____ ☐AM ☐PM
☐**Dept of Mental Health**			____:____ ☐AM ☐PM
☐**DSS Children's Division**			____:____ ☐AM ☐PM
☐**DHSS**			____:____ ☐AM ☐PM
☐**911**			____:____ ☐AM ☐PM
☐**Other (e.g., Coroner or M.E.)**			____:____ ☐AM ☐PM
☐**Other**			____:____ ☐AM ☐PM
☐**Other**			____:____ ☐AM ☐PM
☐**Other**			____:____ ☐AM ☐PM

13. EVENT DESCRIPTION: Describe what happened and interventions used by staff:

Attach additional pages if necessary

14. IMMEDIATE ACTION TAKEN BY AGENCY AND ACTION STEPS TO PREVENT REOCCURENCE (To be completed by agency management if action was required)

If a death occurred: Suspected Manner of Death ☐**ACCIDENT** ☐**HOMICIDE** ☐**NATURAL** ☐**SUICIDE** ☐**UNDETERMINED**

Is an Autopsy being performed? ☐**YES** ☐**NO** ☐**Unknown If Yes, list Coroner/Medical Examiner:**_____

15. Signature-Reporter **Phone Number ( )** **Agency Name**

Date ____/_____/_____ _____:_____ ☐AM ☐PM

Also print reporter name:

To be completed by Department of Mental Health Staff

16. ACTION/ COMMENTS

Incident Type

☐ Consumer Self Harm
☐ Violation of Consumer Rights
☐ Consumer struck object resulting in injury
☐ Fall
☐ Fire
☐ Inappropriate language by staff toward consumer
☐ Medical emergency-Consumer
☐ Misuse of consumer funds/property
☐ Physical altercation-between consumers
☐ Physical altercation-consumer & non-staff
☐ Physical altercation-Staff & Consumer
☐ Possession of weapon
☐ Property loss/destruction
☐ Sexual conduct–consumer/non-consensual
☐ Sexual conduct–staff & consumer
☐ Suicide attempt
☐ Theft by consumer
☐ Vehicular accident
☐Other_____

Was the event a Critical Incident? ☐**YES** ☐**NO** If yes to either question, must be entered into EMT within 24 hours

Suspicion or Allegation of Abuse, Neglect or Misuse of Consumer Funds/Property? ☐**YES** ☐**NO**

Decision: ☐**Inquiry** ☐**Local Review** ☐**Death Review** ☐**No Action Taken** ☐**CO Investigation Requested**
Result: ☐**Declined** ☐**Accepted**
NOTES:

Check any of the following contacts that are required: ☐**DMH Facility Head** ☐**Parent/Guardian** ☐**Local Law Enforcement** ☐**DHSS** ☐**DSS**

Signature of ADA/CPS staff: _____**Date**_____/_____/_____